Bureau of Quality Improvement Services (BQIS)

Incident Data and Recommendations

Incident Communication **07/01/2012 through 09/30/2012**

BUSINESS NAMEQIS

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Introduction

The Division of Disability and Rehabilitative Services (DDRS) Bureau of Quality Improvement Services (BQIS) utilizes an incident reporting and management system as an integral tool in ensuring the health and welfare of people receiving services from one of the Home and Community-Based Services (HCBS) waivers administered by the Bureau of Developmental Disabilities (BDDS). Effective 9/1/2012, the name of the previous Developmental Disability (DD) waiver changed to CIH (Community Integration and Habilitation) waiver. In addition, the previous Support Services (SS) waiver changed to the FSW (Family Supports Waiver). The data for the previous Autism (AUT) waiver will also be incorporated into the CIH waiver.

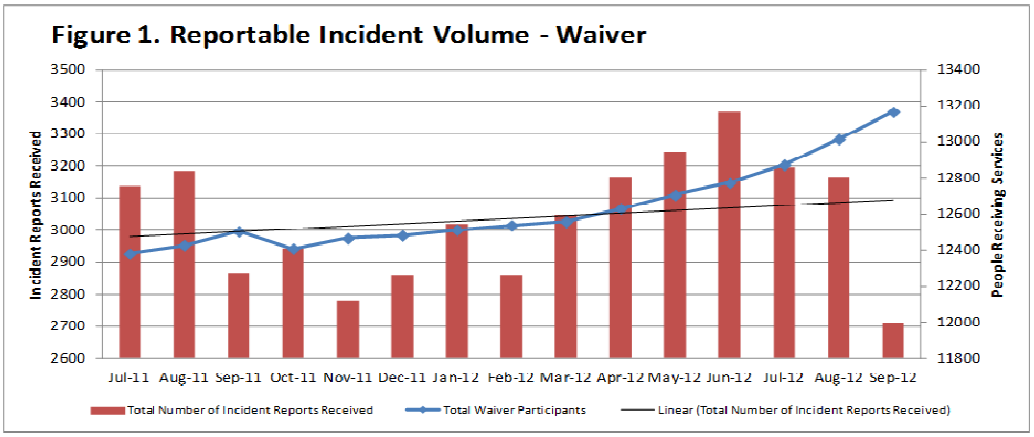
This communication provides at least twelve months of selected categories of incident data for people on a waiver. The data is presented in order to share trends and recommendations with the provider community and other interested stakeholders.

The criteria of a reportable incident can be found in the DDRS Incident Reporting and Management Policy located at http://www.in.gov/fssa/files/Incident_Reporting_and_Management.pdf. In addition, there is a webinar presentation and a Frequently Asked Questions (FAQs) document relative to Incident Reporting located on the BQIS website at http://www.in.gov/fssa/ddrs/3838.htm.

General Incident Data for People Receiving Waiver Services

Even with the reduction of initial incident reports submitted in September 2012, the trend line for the reportable incident volume has shown an upward trend since July 2011. Reviewing the data by quarter instead of by month shows the lowest number of reports (8587) submitted in 2Q FY12 (October-December 2011) and the highest number of reports (9778) submitted in 4Q FY12 (April-June 2012) with a variation of just 1191 between the high and low quarters. As noted in Figure 1, the same pattern exists for August and September 2011 as August and September 2012.

Figure 1. Reportable Incident Volume - Waiver



General Incident Data for People Receiving Waiver Services (Cont.)

The number of people receiving services through one of the HCBS waivers is presented in Table 1 to be used as a frame of reference.

Table 1. Number of People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12
CIH Waiver	7152	7194	7200	7195	7201	7203	7214	7227	7230	7223	7260	7830
AUT Waiver	465	485	491	505	508	524	536	546	550	552	561	58
FS Waiver	4793	4788	4792	4814	4830	4833	4881	4933	4994	5099	5195	5280
Total Waiver Participants	12410	12467	12483	12514	12539	12560	12631	12706	12774	12874	13016	13168

Incident Processing

The timelines for incident processing include the provider/mandated reporter submitting an incident report (IR) through a Web-based application within 24 hours of initial discovery of a reportable incident. The incident report is processed to determine whether or not appropriate and sufficient actions to remedy the situation, prevent chances for recurrence, and to ensure the person's immediate safety have been taken. Based on this determination, the incident is either marked as closed or marked as additional follow-up is required. The incident reporting system automatically generates an e-mail to a designated distribution list to notify them whether or not a follow -up report is required. A follow-up report is required if immediate protective measures were not included in the initial incident report. The responsible person (per *DDRS Incident Management and Reporting Policy*), along with input from the support team, submits follow-up reports for incidents determined to need follow-up within seven days and every seven days thereafter until the incident is resolved to the satisfaction of all entities.

The data for the last two quarters for the number of incidents reported within time period was calculated using the date of knowledge instead of the date of incident. As noted in Table 2, this improves the percentage of incidents reported within 0-1 days; however, this also presents a bit of a lag in ensuring health/safety. **It is essential that provider agencies and other interested stakeholders continue to be diligent with examining and modifying internal processes to work toward closing the gap between the date of the incident and the date of knowledge. Providers must also ensure that staff are knowledgeable of the incident reporting requirements.**

Table 2. Number and Percentage of Incident Reports Reported within 24 Hours of Discovery for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Total Number of Incident Reports Received	2945	2782	2860	3021	2862	3048	3166	3244	3368	3195	3165	2712	3030.67
Total Number of Incidents Reported within Time Period (0-1 days)	2156	1991	2100	2282	2141	2277	2885	2929	3104	2940	2933	2538	2523.00
Percentage Reported within Time Period (0-1 days)	73.21%	71.57%	73.43%	75.54%	74.81%	74.70%	91.12%	90.29%	92.16%	92.02%	92.67%	93.58%	83.25%

The percentage of incidents resolved within the stipulated time period for July and August 2012 are significantly lower (53.96% and 55.83% respectively). One of the variables that potentially contributed to this decrease is the fluctuation surrounding additional case management agencies as of 9/1/2012. A significant number of incident report e-mails sent out had an auto-reply that the case manager was on vacation or no longer employed. While the case management agency had e-mails forwarded internally, the volume could have pushed the resources to the limit. As seen in Table 3, September's percentage is on the way to returning to previous levels.

Providers must remain vigilant in resolving (and documenting) incidents in a timely manner. Providing answers to the questions that were included in the *follow-up required* e-mail is important. For instance, if a person was hospitalized, include the discharge diagnoses and any discharge instructions that will prevent/reduce the likelihood of a recurrence; if there was a

Incident Processing (Cont.)

medication error, include whether there was any negative outcome as a result of the medication error and what steps have been taken to reduce the likelihood of additional medication errors; if there was a fall resulting in injury, include information on whether a fall prevention plan has been developed/revised and if staff have been trained/retrained on the plan; etc. Including information on how the agency/team will monitor to ensure a similar situation does not occur in the future provides information on the longer-term resolution/systemic action.

Table 3. Number and Percentage of Incident Reports Resolved within Stipulated Time Period for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Total Number of Incident Reports Received	2945	2782	2860	3021	2862	3048	3166	3244	3368	3195	3165	2712	3030.67
Number of Incidents Requiring	1962	1741	1843	1911	288	1877	2025	1981	2047	1911	1976	1639	1766.75
Total Number of Incidents Re-	2944	2782	2858	3020	2844	2868	3162	3191	3036	1929	1918	2254	2733.83
Total Number of Incidents Resolved within Stipulated Time Period (30 days)	2794	2636	2675	2836	2693	2822	2955	2994	3002	1724	1767	2251	2595.75
Percentage of Incidents Resolved within Stipulated Time Period (30 days) (Resolved/ Received)	94.87%	94.75%	93.53%	93.88%	94.10%	92.59%	93.34%	92.29%	89.13%	53.96%	55.83%	83.00%	85.65%

At the time the initial incident report is processed, the incident reviewer also evaluates if an incident meets the criteria of being a sentinel event. Sentinel events are situations where a person is/was at significant risk and immediate safety measures need to be in place. Allegations of abuse, neglect and exploitation are considered sentinel events. In addition, elopement when health and welfare are at risk, choking incidents requiring intervention, suicide attempts, arrests, alleged criminal activity by a person receiving services, significant injury/health risk, (e.g., fracture, etc.), and prohibited techniques (e.g., mechanical restraint for behavioral purposes, prone restraint, seclusion, use of aversive techniques) meet the criteria of a sentinel event. It is possible that additional incidents will be made sentinel based on the information provided (e.g., hospitalizations, fire, etc.).

In the event an incident is made sentinel, the case manager makes either face-to-face or phone contact with the provider within 24 hours of notification of the sentinel event. Sentinel status will remain unresolved until there is documentation in either the initial incident report or a follow-up report that appropriate action(s) was taken to resolve the issue. When documentation ensuring health and welfare is confirmed, the sentinel status is resolved.

The percentage of sentinel events resolved within three days improved in July 2012 through September 2012 with all three months above the monthly average of 85.97%. **Providers are reminded of the importance of ensuring immediate safety measures are taken.** Depending on the nature of the incident, immediate safety measures can vary; however, some of the more common safety measures include suspending staff from duty pending the outcome of the investigation for an allegation of abuse, neglect or exploitation involving staff; taking action (e.g., developing/revising a choking prevention plan, retraining staff, providing closer supervision/ monitoring at least for the short term, etc.) prior to the next time a person eats/takes medication in the event of a choking episode; and taking immediate action (e.g., staff training, revision of fall prevention plan, etc.) in the event of a fracture.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Total Number of Sentinel Events	354	369	392	419	387	324	483	417	469	406	493	382	407.92
Total Number of Sentinel Events Resolved within Stipulated Time Period (3 days)	311	351	352	372	338	282	381	310	353	360	456	342	350.67
Percentage of Sentinel Events Resolved within Stipulated Time Period (3	87.85%	95.12%	89.80%	88.78%	87.34%	87.04%	78.88%	74.34%	75.27%	88.67%	92.49%	89.53%	85.97%

Abuse, Neglect and Exploitation

The allegations of abuse, neglect, and exploitation included in Table 5 and Figure 2 are inclusive of the alleged perpetrator being a staff person, a family member/guardian, a community person, and in a small number of cases, a peer. There was a high of 194 allegations of neglect reported in April 2012. Allegations of neglect continue to be the most frequently reported type of allegation accounting for 44.46% of the total number of allegations of abuse, neglect and exploitation reported.

There are at least two training modules required for case managers regarding incident reporting/sentinel events. The content of these training modules includes definitions, actions, and the role of the case manager – an advocate for the person receiving services.

Provider agencies are required to conduct annual training on incident reporting which includes allegations of abuse, neglect, and exploitation (ANE). Resources available on the BQIS Incident Reporting web page (http://www.in.gov/fssa/ddrs/3838.htm) include a webinar covering the updated policy which took effect March 1, 2011 along with Frequently Asked Questions (FAQs).

Some of the key areas include:

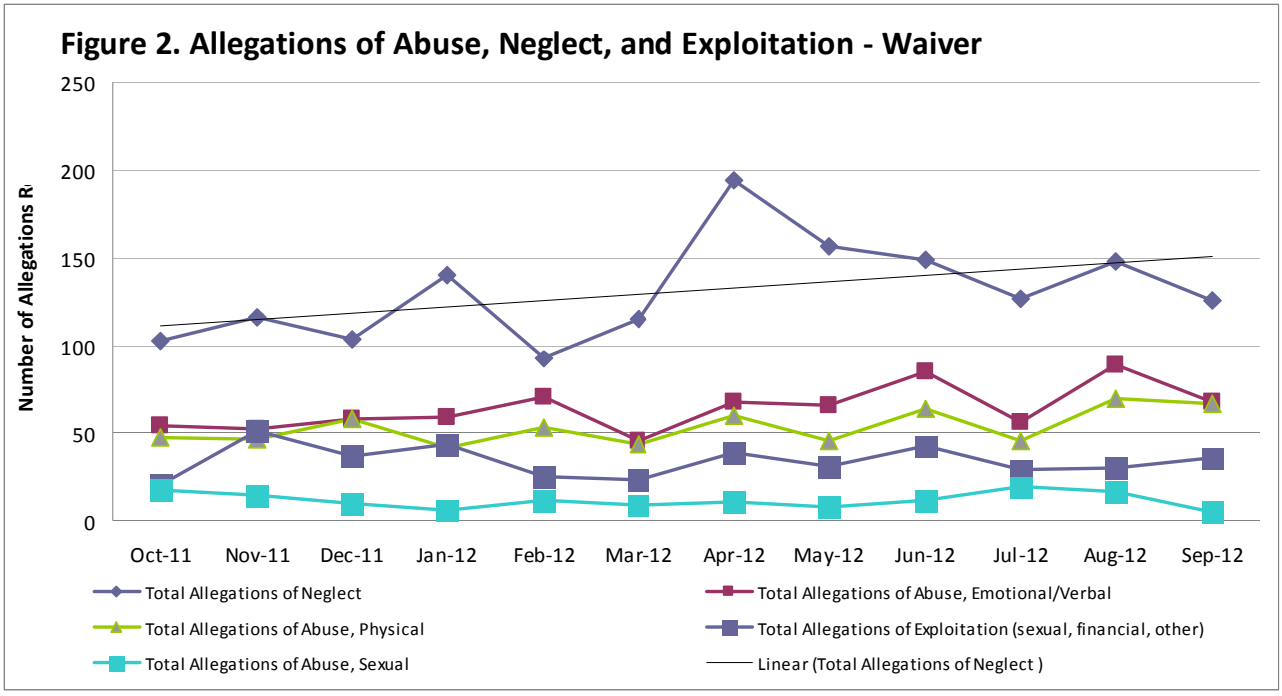
- The overriding guideline in the DDRS Incident Reporting and Management Policy.
- The principle of "when in doubt, err on the side of the consumer."
- The importance of honest reporting.
- The importance of taking both short-term and long-term corrective action to ensure health/safety.
- Regardless of who makes an allegation (e.g., consumer – regardless of history of false allegations, family member, direct support staff, management staff, community person, etc.), it is still an allegation and needs to be handled as such - reported, immediate protective measures taken, investigated, appropriate action(s) taken, etc.
- The components of the initial incident report narrative – who, what, where, when, why, how. What immediate protective measures have been taken?
- Ensure the initial narrative report is clearly communicating why the reporting person is submitting an incident report.
- The follow-up report should not be a copy/paste of the initial incident report.
- The importance of appropriate and timely communication of team members. For example, submitting an incident report does not take the place of members of the team communicating with each other to resolve the issues that contributed to the incident.

Table 5. Allegations of Abuse, Neglect, and Exploitation Involving People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Total Allegations of Neglect	103	116	104	140	92	115	194	157	149	127	148	126	130.92
Total Allegations of Abuse, Emotional/Verbal	54	52	58	59	70	45	67	65	85	56	88	67	63.83
Total Allegations of Abuse, Physical	47	46	58	41	53	43	60	45	63	45	69	66	53.00
Total Allegations of Exploitation (sexual, financial, other)	20	51	37	43	25	23	38	31	42	29	30	36	33.75
Total Allegations of Abuse, Sexual	17	14	10	6	12	9	11	8	12	19	16	5	11.58
Grand Total	241	279	267	289	252	235	370	306	351	276	351	300	293.08

The analysis of allegations of abuse, neglect, and exploitation since the implementation of the revised *DDRS Incident Reporting and Management Policy* on 3/1/2011 identified some issues. One of the issues was that the quality of internal investigations is quite varied. The *DDRS Mandatory Components of an Investigation Policy* (http://www.in.gov/fssa/files/Mandatory_Components_of_an_Investigation.pdf) was published with an effective date of 3/16/2012.

Abuse, Neglect and Exploitation (Cont.)



Providers should review their own policy and practices, review a sampling of their internal investigation (e.g., does the information contained in the investigation support the outcome/result, are systemic issues identified and addressed as a result of the investigation?) and obtain technical assistance in this area if appropriate.

The number of allegations substantiated by each provider ranges from 0% substantiated to 100% substantiated. As noted in Table 6, allegations of neglect continue to be substantiated the highest percentage of the time; however, there is a downward trend present in the last three months. While the percentage of allegations of exploitation continues to be substantiated slightly less than allegations of neglect, this category also presented with a downward trend from April 2012 through June 2012. Allegations of physical abuse are substantiated the lowest percentage of the time. Low rates of substantiation may be indicative of a faulty or insufficient investigation.

Table 6. Percentage of Allegations of Abuse, Neglect, Exploitation Substantiated for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Allegations of Neglect	46.60%	52.59%	57.69%	44.29%	51.09%	47.83%	62.37%	50.32%	43.62%	59.06%	55.41%	44.44%	51.27%
Allegations of Exploitation (sexual, financial, other)	50.00%	50.98%	54.05%	44.19%	36.00%	39.13%	55.26%	48.39%	40.48%	48.28%	53.33%	44.44%	47.04%
Allegations of Abuse, Emotional/Verbal	50.00%	40.38%	31.03%	45.76%	24.29%	51.11%	35.82%	33.85%	30.59%	26.79%	42.05%	19.40%	35.92%
Allegations of Abuse, Sexual	23.53%	28.57%	30.00%	16.67%	16.67%	44.44%	27.27%	37.50%	33.33%	26.32%	25.00%	20.00%	27.44%
Allegations of Abuse, Physical	31.91%	28.26%	36.21%	14.63%	30.19%	23.26%	25.00%	31.11%	20.63%	28.89%	27.54%	25.76%	26.95%

Another issue is that staff are not suspended from duty pending the outcome of the investigation 100% of the time when there is an alleged, suspected or actual abuse, neglect or exploitation incident. Table 7 provides information on the percentage of times when staff were suspended in compliance with IAC 460 regulations.

A field for noting whether the staff person was suspended from duty pending the outcome of the investigation was added to the database effective 11/1/2011. This immediate safety measure (removing the alleged perpetrator from duty to reduce risk to the alleged victim and others) should be clearly stated as part of the initial incident report, but there are times when it is not. There are other

Abuse, Neglect and Exploitation (Cont.)

times when the initial incident report and a follow-up report(s) have a discrepancy on whether or not staff were suspended from duty.

It is encouraging to see the upward trend in compliance with suspending staff (when the alleged perpetrator) for both allegations of physical abuse and neglect. Providers continue to be reminded of this regulation as part of the incident review process and also as part of the provider review process.

Table 7. Percentage of Allegations When Staff (Alleged Perpetrator) Was Suspended Pending the Outcome of the Investigation for People Receiving Waiver Services.

Description - % of Allegations when Staff was Suspended	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Allegations of Abuse, Emotional/Verbal	90.50%	79.10%	86.70%	89.40%	86.70%	88.68%	88.24%	88.89%	92.16%	88.31%	96.43%	88.65%
Allegations of Abuse, Physical	100.00%	88.60%	60.70%	88.10%	93.10%	86.27%	93.33%	82.35%	85.71%	92.31%	95.56%	87.82%
Allegations of Exploitation (sexual, financial, other)	100.00%	90.50%	73.90%	83.30%	85.70%	83.33%	77.78%	83.33%	93.75%	76.47%	77.78%	84.17%
Allegations of Neglect	77.80%	80.20%	67.40%	75.90%	77.70%	87.70%	78.08%	80.88%	78.99%	83.45%	90.76%	79.90%
Allegations of Abuse, Sexual	66.70%	100.00%	100.00%	50.00%	100.00%	75.00%	75.00%	N/A	25.00%	100.00%	100.00%	79.17%

An excerpt from Indiana Administrative Code 460 6-9-5 Incident reporting:

> "Sec. 5. (a) An incident described as follows shall be reported to the BDDS on the incident report form prescribed by the BDDS: (1) Alleged, suspected, or actual abuse, neglect, or exploitation of an individual. An incident in this category shall also be reported to adult protective services or child protection services as applicable. *The provider shall suspend staff involved in an incident from duty pending investigation by the provider.*"

In the event of an allegation of abuse, neglect or exploitation, the provider must take immediate action to ensure the health and welfare of both the alleged victim(s) and any other people receiving services. In the event a staff person is the alleged perpetrator, this includes suspending the staff from duty pending investigation by the provider.

In some cases, staff were not suspended, but were terminated and/or resigned immediately. The immediate termination and/or resignation ensures an immediate safety measure is in place; however, the current system does not have an option to clearly reflect that. A modification to the IR system is recommended to capture those incidents where staff is terminated immediately/resigned immediately.

In other cases, staff were not scheduled to be on duty (e.g., vacation, off shift, etc.), during the time of the investigation. Based on narrative review, other examples of situations when staff were not suspended were 1) in cases when staff other than a DSP staff person was the alleged perpetrator, 2) the consumer had a history of making false allegations, 3) a specific staff person was not identified until the investigation was concluded, and 4) the agency did not view the incident as abuse/neglect/exploitation.

Providers should review their operating procedure to ensure this requirement – suspended from duty pending the outcome of the investigation - is clearly stated and staff are trained. It is also recommended that other interested stakeholders are reminded of this requirement and the reason for it – i.e., to reduce risk.

In addition, providers need to review their operating procedure/process to ensure that all of the appropriate staff (e.g., the staff person (alleged perpetrator), anyone who schedules staff for overtime or to work in another home/location, and all appropriate supervisory/management/human resources staff) are aware that the alleged perpetrator is not able to work overtime, work another shift, work in another home/location until the investigation is completed.

Providers should also review their data regarding allegations of abuse, neglect, and exploitation along with the data presented in Tables 6 and 7. Are trends tracked – percentage of substantiation per type of allegation; percentage of substantiation per category of reporter (alleged victim, other consumer, staff, family member, community person); are there any variables identified as being consistent issues leading to unsubstantiation; has the agency addressed those variables?

Behavioral Incidents

The number of incident reports of aggression to housemate/peer continues to be the most frequently reported type of behavioral incident with aggression to staff being the second most frequently reported. Reports of aggression to housemates and suicide attempts are trending downward during the past three months while elopement was trending upward during three of the last four months. A point of interest is that the number of submitted reports for all of the categories of behavioral incidents in Table 8 except property damage are below the monthly average. With the increase in waiver participants, this is suggestive of improvement over this period of time.

For those people who have repeat behavioral incidents or who have not demonstrated improvement within the last three months, the team (including the behavioral clinician) should discuss whether a programmatic change might be beneficial. If a person does not currently have a behavioral clinician on the team, one must be consulted to determine if a Behavioral Support Plan (BSP) is warranted.

Table 8. Number of Behavioral Incidents Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Aggression to Housemate/ Peer	184	138	162	142	148	197	176	177	158	182	152	133	162.42
Aggression to Staff	133	75	70	99	110	100	121	111	99	80	84	73	96.25
Self-injurious Behavior	58	70	86	92	82	89	79	91	93	70	75	74	79.92
Elopement	70	60	68	83	71	85	71	81	64	75	82	67	73.08
Property Damage	41	52	39	45	37	39	44	55	56	43	38	46	44.58
Suicidal Thoughts/Ideations	26	26	30	44	35	31	37	38	40	37	40	19	33.58
Aggression to Family/ Guardian	17	12	16	10	16	17	12	12	14	14	18	13	14.25
Aggression to Other Person	19	13	9	8	13	9	17	13	20	16	4	5	12.17
Suicide Attempt	8	8	2	8	9	8	9	8	8	9	5	4	7.17
Pica/Ingestion of Foreign Object	1	3	5	3	5	2	6	3	5	4	3	5	3.75
Assault, Sexual (for perpetrator)	3	1	0	2	4	0	0	3	1	2	1	0	1.42
Alleged Domestic Abuse	1	4	1	1	0	0	0	2	2	1	2	1	1.25
Grand Total	561	462	488	537	530	577	572	594	560	533	504	440	529.83

Behavioral Failures

The state of Indiana prohibits the use of prone restraint (face down on the stomach), mechanical restraint, seclusion, and use of aversive techniques for a person receiving services through a waiver. Please reference the *DDRS Use of Restrictive Interventions Including Restraints Policy* (http://www.in.gov/fssa/files/Use_of_Restrictive_Interventions.pdf).

The teams for people who have had one of these restrictive interventions utilized should review the DDRS policy, revise their operating policy/procedure, review the behavioral support plans (BSP) for the people who were involved to ensure these interventions are not part of the BSP, and retrain staff in these areas. Two people each had one report of seclusion during the past quarter. In addition, three people were each restrained once in the prone position in the past quarter. There were no reports of the use of either a mechanical restraint for behavioral purposes or an aversive technique during this past quarter (Table 9).

The *Community Services Reporter* published by the National Association of State Directors of Developmental Disabilities Services (NASDDS) provides updates on which states prohibit the use of prone restraint and seclusion. Neighboring states that also prohibit the use of prone restraint and seclusion are Illinois, Michigan, and Ohio.

Behavioral Failures (Cont.)

Additional information regarding the danger of utilizing a prone restraint can be found at:

- *Asphyxial Death during Prone Restraint Revisited; A report of 21 cases.* O'Halloran R, et al. The American Journal of Forensic Medicine and Pathology 21(1) March 2000;
- *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint.* Equip for Equality – A Special Report from the Abuse Investigation Unit, 2011.

The teams for people who have had multiple restraints (e.g., manual/physical, PRN medications) utilized in the past six months should seek technical assistance on behavioral intervention strategies. This should include consultation with the Level 1 Behavioral Clinician.

Of the 31 people who were arrested during this quarter, three of them were arrested more than once.

Table 9. Number of Behavioral Failures Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Restraint, Manual/ Physical Restraint Technique - Behavioral Purposes	121	134	108	129	103	114	76	118	111	81	92	67	104.50
PRN Medication - Behavioral Purposes	80	79	82	81	53	77	77	79	90	95	90	84	80.58
Arrested	11	10	19	14	18	13	9	14	16	14	8	14	13.33
Seclusion	1	0	8	1	0	1	2	1	1	1	0	1	1.42
Restraint, prone	1	1	1	2	3	1	0	0	0	1	2	0	1.00
Restraint, Mechanical Restraint Technique - Behavioral Purposes	2	0	0	1	1	0	1	2	1	0	0	0	0.67
Use of Aversive Technique	0	1	0	0	0	0	0	0	1	0	0	0	0.17
Grand Total	216	225	218	228	178	206	165	214	220	192	192	166	201.67

Medication Errors

With the implementation of the revised *Incident Reporting and Management Policy* effective 3/1/2011 which expanded the criteria for reportable medication errors, a significant increase in reported medication errors is noted. The number of medication errors reported in September 2012 is the lowest number reported during the past 19 months (since 2/2011).

From analysis of the types of medication errors being reported, it was noted there were incident reports being submitted indicating the person did receive a medication; however, it was given outside the window of time. In order to capture those instances, an additional coding option of *medication error, given outside window* was added 11/1/2011. Medications must be given within a half hour of the time that is listed on the medication log (Centers for Medicare & Medicaid Services [CMS] *Interpretive Guidelines*; Core A Medication Administration Training). This means that you have a half hour before the medication is due, and a half hour after it is due to administer the medication.

The category of medication error reported most frequently has remained consistent since 3/2011 – medication error-missed dose, not given (Table 10). While there have been a couple of downward trends in this category of medication error, the overall number is significant. While medication errors-wrong dose, showed a steady downward trend in the number of reports from November 2011 to March 2012, there is an upward trend from May 2012 to August 2012 with August 2012 showing the highest number of medication errors of

Medication Errors (Cont.)

this type. The overall frequency of reported medication errors shows a downward trend over the past three months (July 2012 to September 2012).

Table 10. Medication Errors Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Medication error, missed dose, not given	326	308	307	296	278	302	344	322	325	340	289	279	309.67
Medication error, wrong dose	90	100	87	84	72	69	81	67	70	72	102	64	79.83
Medication error, wrong medication	24	25	42	47	42	25	23	29	20	28	36	25	30.50
Medication error, given outside window		11	16	16	26	12	17	21	16	25	24	19	18.45
Medication error, wrong route	2	0	0	1	0	0	0	1	1	0	0	0	0.42
Grand Total	442	444	452	444	418	408	465	440	432	465	451	387	437.33

Staff who administer medication are required to be trained at least annually on a medication administration program. Additional emphasis should be placed on refresher training for those with medication administration errors, that the provider's policies/procedures are reviewed (and revised as needed), that the policies/procedures are implemented as written, and an effective and timely monitoring system for medication administration is in operation. An observation of a medication pass should be part of the provider's ongoing competency-based training program. A sample medication pass checklist is included as part of this quarterly report and communication (page 13 of this communication).

Choking Episodes Requiring Intervention

Definition: Choking is the inability to breathe because the trachea is blocked, constricted, or swollen shut. Choking is a medical emergency. When a person is choking, air cannot reach the lungs. If the airways cannot be cleared, death follows rapidly.

There have been a total of 14 deaths (all funding sources) due to asphyxiation (associated with food/pica/objects/medication/vomitus) from October 2011 through September 2012 with one of these deaths occurring this quarter. The total number of choking episodes requiring intervention for people receiving waiver services are noted in Table 11.

Table 11. Number of Choking Episodes Requiring Intervention Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Choking Requiring Intervention	15	12	11	11	8	11	11	11	11	12	10	9	11.00

If a person has a choking episode requiring intervention, the initial incident report, follow-up report(s), and other pertinent documentation are reviewed to determine what actions have been taken to prevent another choking episode. **What safety measures have been put in place before the next time the person eats/drinks/takes medications?** The interdisciplinary team should also identify future action(s) as a longer term remedy, but it is important to implement some immediate safety measure(s).

There have been several choking episodes requiring intervention where the person already had a choking prevention plan and still choked. In these cases, the current plan was not effective for some reason. **How did the team address the failure of the current plan?** It is possible the plan itself was fine, but the failure was due to another variable (e.g., staff were not implementing the plan correctly, the appropriate supervision was not in place, etc.). If those factors contributed to the choking episode, the immediate safety

Choking Episodes Requiring Intervention (Cont.)

measure must address those identified variables.

People are at risk in all locations. Individual-specific choking prevention/dining plans must be available and consistently implemented in all locations (e.g., home, day program, restaurant, church events, the family home, other special events (Special Olympics), etc.) and staff/ natural supports in all locations need to be trained on the current plans.

Many choking prevention/dining plans have a statement, "food should be cut into bite-size pieces." While at first glance this statement appears as an adequate guideline for staff, there is a lot of room for interpretation and as a result, the person is at risk. Interdisciplinary (ID) teams should review current choking prevention/dining plans and replace the phrase "bite-size" with a more descriptive and measured term that is appropriate to the individual person such as "pieces no bigger than a quarter," "pieces the size of a quarter to half-dollar," "sandwich is to be cut into ¼ pieces," etc. The choking prevention/dining plan should also include visual cues of the actual size of the item (e.g., an actual-size picture of a quarter, a visual cue staff can use to verify that food of a different original shape is presented to the person correctly, etc.). In addition, if there are food items that are troublesome and/or prohibited due to the person's choking risk, these food items should be listed in the choking prevention/dining plan.

There are many reasons a person might be considered an unsafe eater. If it is a behavior, the dining plan may include verbal or physical cues to slow down the rate of eating (e.g., place the utensil on the table between bites, use the napkin to wipe mouth/chin, take a sip of liquids between bites, present the food in smaller portions (plate to plate method) to assist with take smaller bites, etc.), chew more thoroughly, and/or not to talk/laugh with food/liquids in the mouth.

An individual with dementia is also at risk of being an unsafe eater. For instance, the associated forgetfulness may not allow him/her to recall the need to cut food into bite-size pieces, to chew completely, or to swallow without prompts. The swallowing function can deteriorate slowly, as in Alzheimer's disease, or rapidly, as in a stroke. Staff need to be within view or at tableside for appropriate supervision and observation of the person because there may be no other warnings of functional decline.

Another situation is that if a person has a history of repeated pneumonia or aspiration pneumonia he/she may have a component of dysphagia. There may also be a component of gastroesophageal reflux disease (GERD) in which stomach acid/contents are aspirated. In such instances, direct supervision is appropriate to ensure proper positioning at all times during dining, to ensure there is no distraction while eating, and to observe for dysphagia triggers.

A checklist of questions/probes regarding a choking episode is available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm) and should be used by the team to address any identified variables that contributed to the choking episode. The checklist can also be utilized as a proactive risk management and educational tool for ID teams.

Additional resources include:

- http://www.in.gov/fssa/files/Mortality_12.27.11.pdf
- http://www.in.gov/fssa/files/Choking_Checklist.pdf
- http://www.in.gov/fssa/files/Morality_Communication_7_9_12.pdf
- http://www.in.gov/fssa/files/Quarterly_Report_MR_1.31.12.pdf

Emergency Room Visits and/or Hospital Admissions, Medical and Psychiatric

The number of incidents associated with ER Visits (for medical reasons) has varied during the past twelve months with a monthly average of 539.5 ER visits for medical reasons calculated on twelve months of data (Table 12). While the reasons for an ER visit or a hospital admission can be varied, the underlying factor is that a change in status (real or perceived) was noted. A variety of fact sheets and resource materials relative to recognizing and responding to changes in health status and medical conditions/situations are available on the BQIS website (http://www.in.gov/fssa/ddrs/2635.htm). Providers should incorporate these materials into their operating policies/procedures and individual-specific risk plans and ensure staff are trained.

The number of in-patient hospitalizations for medical reasons presents two upward trends - late fall/early winter (November 2011 through February 2012) and another upward trend in early summer to early fall (June 2012 through September 2012) (Table 12). Based on review of data for the past nine months, an average of 31.20% of ER visits for medical reasons lead to hospitalizations with an upward trend noted from May 2012 through September 2012 (Table 13).

ER visits for medical reasons also presents two upward trends with the most recent one during the summer months (June through August 2012).

ER Visits and/or Hospital Admissions, Medical and Psychiatric (Cont.)

Both ER visits and in-patient hospitalizations for psychiatric reasons began trending upward beginning in April 2012, reached a high in July and June respectively, and since then have been trending downward.

Table 12. Number of ER Visits/Hospital Admissions Reported for People Receiving Waiver Services.

Description	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Emergency Room Visit - Medical	510	466	529	512	540	557	547	587	536	563	569	558	539.50
In-patient Hospitalization - Medical	163	152	157	170	174	173	178	163	147	165	168	170	165.00
Emergency Room Visit - Psychiatric	49	48	49	75	57	71	60	64	75	86	60	47	61.75
In-patient Hospitalization - Psychiatric	43	23	34	44	43	45	43	46	56	42	38	29	40.50

Table 13. Number and Percentage of ER Visits Leading to In-patient Hospitalizations (for medical reasons) for People Receiving Waiver Services.

Description	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average
Number of ER Visits Leading to In-patient Hospitalizations (for medical reasons)	169	174	174	178	164	150	165	167	174	168.33
% of ER Visits Leading to In-patient Hospitalizations (for medical reasons)	33.01%	32.22%	31.24%	32.54%	27.94%	27.99%	29.31%	29.35%	31.18%	31.20%

Reports of falls with injury contributed the highest number of ER visits for eight of the past nine months falling to the number two spot in April 2012. The total for the top seven reasons for ER visits contributed between 58%-74% of all ER visits with an average of 61%. When reviewing the information in Table 14, providers should be mindful of people who have similar issues who are receiving services through their agency. Is there an individual-specific risk plan in place? Does the risk plan have both proactive as well as reactive components? Have all of the staff received recent training on the person's individual-specific risk plan?

Table 14. Top Seven Reasons for Emergency Room Visits (for medical reasons) for People Receiving Waiver Services

Top 7 Reasons for ER Visit (medical)	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Average	Total
Fall with injury	72	74	76	69	92	67	82	98	74	78.22	704
Nonspecific health status change	54	61	67	72	72	63	70	55	57	63.44	571
Respiratory issue	58	56	47	55	42	41	27	49	54	47.67	429
Genitourinary/Renal	42	46	48	45	43	49	45	49	51	46.44	418
Seizure activity	42	36	35	36	52	42	40	40	32	39.44	355
Digestive system, upper GI	34	39	33	36	34	38	48	44	42	38.67	348
Digestive system, lower GI	23	33	32	41	26	26	23	22	40	29.56	266
Total of top 7 Reasons for ER Visit (medical)	325	345	338	354	361	326	335	357	350	343.44	3091
Top 7 Reasons / Total ER Visits	63.73%	74.03%	63.89%	69.14%	66.85%	58.53%	61.24%	60.82%	65.30%	61.00%	

ER Visits and/or Hospital Admissions, Medical and Psychiatric (Cont.)

If a person goes to the ER, the IDT needs to request a copy of the ER record and in the event a person is hospitalized, the IDT needs to request a copy of the hospital discharge summary and patient discharge instructions. These documents contain information that should be incorporated into existing risk plans, used to develop individual-specific risk plans (for new diagnoses), timely communicated to team members, and used for staff training purposes.

The teams for people who have had multiple ER visits and/or hospital admissions within the past three months should take a close look at the person's diagnoses, the risk plans in place, staffing levels, the home environment, and other relevant factors and have an honest discussion among the team members (including the consumer, guardian, physician, etc.) on whether the current setting can meet the person's current needs. Another option for teams to consider would be scheduling more frequent visits designed to proactively meet the person's medical needs and provide additional opportunity for health care professionals to observe and identify more minor changes to health status that a lay person may miss.

Resources Regarding Incident Reporting and Management

The link to the DDRS Incident Reporting and Management Policy is http://www.in.gov/fssa/files/Incident_Reporting_and_Management_3-1-11.pdf.

In addition, the link to the Frequently Asked Questions (FAQs) relative to Incident Reporting is http://www.in.gov/fssa/files/FREQUENTLY_ASKED_QUESTIONS_TABLE_OF_CONTENTS_3-8-11.pdf.

Additional information related to specific topics (e.g., seizure management, UTIs, hospital discharge, etc.) are available in the Mortality Data and Recommendations found on the BQIS.in.gov website.

On-Site Medication Assessment (OSMA)

PRINT Name: _____ Signature: _____

Observer: _____ Agency: _____

Employee must demonstrate the ability to prepare, administer and record the administration of medication by successfully completing the steps noted below. A trial is defined as a pour and pass of one medication. **Staff must complete 2 trials with 100% accuracy.**	Use the following codes to indicate performance: S = Satisfactory; U = Unsatisfactory; N/A = Not Applicable			
	/ /	/ /	/ /	/ /
Assembles appropriate equipment: Medications, med cups, water, etc.				
Uses good hand washing techniques				
Checks MAR against prescribed orders (with each new MAR)				
Selects appropriate meds for the time being given				
Compares drug labels to MAR x 3 (MAR present and used through entire med pass)				
Observes the six (6) rights of Meds Pass (Right person, Right medication, Rights dose, Right route, Right time, Right documentation)				
Observe the individual's condition for any signs of illness or altered state (e.g., drug interaction). Check for vital signs being taken (if required)				
Correctly administers medication (e.g., route, with water, food, etc.)				
Ensure meds are taken/swallowed (identify potential swallowing issue)				
Documents medication correctly on MAR before proceeding to the next person (should include initials/full signature in appropriate place, etc)				
Washes hands between Individuals				
Medications are kept in a secure location at all times				
Staff does not leave meds unattended/med pass area during med pass				
Staff locks medication area before leaving the area.				

Follow Up Questions about Medication:	/ /	/ /	/ /	/ /
Check staff knowledge of Medications (Desired effect, Potential Side effects, Side Effect monitoring)				
Check staff knowledge missed medications, medication refusals and Medication errors.				
Check staff knowledge related to use of PRN medication (i.e., documentation on back of MAR, reason for use, response and signature)				

Notes: _____